THE FUTURE OF HEALTH CARE IN AMERICA

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I want to discuss the future of health care in America. I especially want to talk about financing health care.

That's not only because this issue plays a major role in my daily life as Administrator of the Health Care Financing Administration...but also because it plays a major role in all our lives.

So forgive me if I address you sounding more like an economist than a physician. I spend a lot of time these days with economists, and lawyers as well.

My task in Washington is to run the Medicare and Medicaid programs, a $110 billion annual enterprise.

Our agency is usually known by its four-letter acronym, HCFA, which is often a favorite four-letter cuss word in the medical community.

HCFA is constantly vilified as a bureaucracy bent on interfering in medical decisions.

I can remember being at a gathering where, after finishing my description of Medicare's proposed agenda, a man stood up in the audience and said that all he wanted to do was "get the government out of the Medicare program."

But of course, the government IS the Medicare program. And Medicare is a dominating force in American health care, whether we like it or not.

So we have to face the reality that the government is a primary partner in health care. That's the way it is, and the best way I can help you to shape your futures is to tell it the way it is.

I wish I could say that everything is coming up roses. But it isn't. It is difficult being involved in health care today...and it will be increasingly more difficult.

Yet there is a bright side. These challenges will make medicine a better profession, and we all need to take our duties very seriously.

With that in mind, I would like to discuss two important issues.

First, I want to talk about quality in health care, with an emphasis on the government's role in measuring quality care.

In this vein, I will talk about our release of hospital mortality data, and tell you about our upcoming plans to measure the effectiveness of care.

Second, I would like to broaden the discussion, to consider some of the problems with the current micromanagement of health policy, as well as some suggestions for the future direction of American medicine.

I. Quality

Everybody today is for quality, but we need to ask very seriously what quality is -- how to define it, and how to measure it.

It is nonsense to pretend that all doctors and all hospitals offer care of equal quality, because they don't. And we should be at the forefront in discriminating among physicians and hospitals, pointing out our findings to our patients.

Quality Information

Medicare has been actively involved in finding new methods for statistically measuring quality of care.

In December 1986 we convened a quality of care symposium which included professionals from consumer groups, hospital groups and the AMA.

These discussions lead directly to last December's release of information on mortality rates for Medicare patients at nearly 6,000 hospitals nationwide.

We pulled out all the stops in making sure that this information was used in an informative way.

We held workshops to educate the media, and I held several interviews. Through it all, we were careful to point out that this information was not a perfect measure of quality of care. Rather, it was a first step.

The information isn't appropriate for ranking or comparing hospitals. Rather, it is designed to provide an incentive for physicians to look carefully at the way they practice their profession. And to encourage patients to pose thoughtful questions.

We decided to release this information NOT because we had to, or because it was required by Congress, but because it was the right thing to do. This information is an important contribution to the existing body of knowledge about health care.

We plan to continue to improve our measurement of quality of hospital care. And we intend to go beyond that to measure the quality of care given by other providers, including nursing homes, HMOs, and ultimately, individual physicians.

With current computer technology, such measurement is well within our grasp. To some, all of this is very threatening. But I encourage you to see it as an opportunity to be leaders, rather than reluctant followers.

If you believe, as I do, in a more competitive health care system, you must agree to provide more information, to build an informed public.

To that end we will be releasing a publication shortly that provides detailed information on Medicaid and Medicare nursing home quality. And we will publish our report on Medicare hospital mortality again this year.

Effectiveness

We've spent much of 1988 focusing our attention on the next level of analysis of measuring quality: effectiveness.

This sort of study goes by many names, but the essence of our effort is to find out what works in the practice of medicine.

Every year, we as a nation spend billions of dollars advancing the frontiers of knowledge in medical research.

Yet when it comes to some very practical matters, we are woefully uninformed.

We have a lot more to learn about the relative efficacy of various treatments, their cost-effectiveness, and the benefit of additional medical services.

We are convinced that efficacy is an important priority, and we are prepared to commit Medicare trust fund dollars to determine the proper role we must play in the effort.

A growing body of medical literature indicates that some of the increased utilization of health care services fails to improve the quality of care.

Studies by Wennberg, Brook, Eddy and others are producing information that seriously questions how doctors utilize many medical procedures...including common angiography, carotid endarterectomy, upper GI endoscopy, cardiac pacemaker implants and coronary artery bypass grafting, to name a few.

In our upcoming studies of effectiveness, we will coordinate our work with other government agencies, including the Public Health Service. We would also like to involve the AHA, the AMA, and other provider groups, together with insurers, consumers and Medicare beneficiaries.

We have made important progress in the past few months toward marshalling our resources, principally data and dollars, to foster better information on effective medical practice.

This emphasis on effectiveness of care is a central part of Medicare's future. Indeed, the agenda we set now will shape HCFA long after I leave office. I welcome you to participate in this exciting new frontier.

II. Micromanagement

Naturally, we believe that our recent efforts to measure quality have great merit.

Yet I wonder if the same can be said about the massive outpouring of legislation that has cascaded out of Congress in recent years.

Perhaps some of you remember the way President Reagan, during his State of the Union message, graphically illustrated the sheer bulk of recent Congressional budget handiwork.

One of those two massive bills, the Omnibus budget Reconciliation Act or OBRA '87, contains literally thousands of lines of fine print affecting the Medicare program.

The draft implementation plan for OBRA '87 prepared by our HCFA staff is 45 pages of fine print, detailing the new agency responsibilities.

Another HCFA document, on the status of reports due to Congress, contains another 24 pages.

In the light of Congress's handiwork, let me quote from the 62nd Federalist Paper. In it, James Madison wrote:

> It will be of little avail to the people that the laws are made by men of their own choice if the laws are so voluminous that they cannot be read, or so incoherent that they cannot be understood; if they be repealed or revised before they are promulgated, or undergo such incessant changes that no man, who knows what the law is today, can guess what it will be tomorrow."

Perhaps Mr. Madison had premonitions of Medicare when he wrote that.

A major choice we continue to face in health care is whether to centralize or decentralize decision-making authority in the system.

Centralization has some advantages. But America is diverse, and a diversity of voices contributes more to health care policy than a handful of Washington policymakers and bureaucrats.

Let me apply this principle to the present and future of Medicare.

Hospital Payment

The Reagan Administration has made a serious push for more competition in health care, including market forces and appropriate incentives.

And health care has changed in the past few years; indeed, it is often described as a "revolution." Of course, the bulk of this revolution took place in 1983, with the passage of the hospital prospective payment system.

PPS has made the greatest impact on the health care system of any policy in recent years. It gives hospitals important incentives to deliver health services efficiently -- and it is a dramatic improvement over the old cost-reimbursement system.

But PPS is a centrally administered national price payment system, not price competition. The only "competition" among hospitals now is to provide better amenities to attract more patients.

Recently we have focused more carefully on the continuing increase in cost per case under PPS. Despite strong counter incentives, costs continue to rise.

On the one hand, this finding may lead us to conclude that we have not squeezed hospitals hard enough, a conclusion that I know will find few sympathizers here.

On the other hand, we may have given hospitals a terribly difficult task. It is open to question whether hospitals really can control the physician decisions that drive health care spending.

Thus, we face a serious question: How much more can Medicare safely economize in the hospital sector?

Reducing the over-supply of hospital beds is one alternative.

Given low occupancy rates, one big way to curtail Medicare hospital spending is to find the political will to allow some hospitals to go out of business.

However, I believe that it is implausible to rely on such political will -- especially given our current experience with the rural hospital sector.

As PPS has pinched more tightly in rural America, the Congress has responded with special rural rules and higher rural payment updates. Some of the changes were warranted, and advocated by HCFA as sound policy.

However, other changes. contemplated or proposed, fly in the face of knowledgeable observers who recognize that some rural hospitals need to change or even close.

In my view, it is the job of Medicare to assure access to quality health care services. However, it is clearly not our job to keep every hospital open.

Adorning a national price system with local "fixes" is simply not the answer. Let's be clear: Prospective Payment is vastly superior to cost-reimbursement, but it has limitations.

Physician Payment

Part A hospital expenditures do not constitute our main problem now. Part B physician spending is literally out of control. As a result, in January the Part B premium rose 38.5 percent.

This change is brought about by many factors, and chief among them is the burgeoning utilization of Part B services.

We know that much of the increase in utilization is good and is to be applauded -- it reveals that doctors are doing more for their patients. But we also know that some of the increase is unnecessary.

Yet I believe that we need to question what has become a fundamental premise of the American health care system: that "More is better." Indeed, more is not necessarily better.

We need seriously to examine practice patterns and to reach consensus about appropriate patterns.

Until recently the burden of proof in this debate has been on the bureaucrats who sought to have doctors provide less to save more. But the issue has grown beyond that.

As we look for ways to constrain Part B spending growth, using incentive payment systems like PPS for doctors will be difficult.

Also, since utilization growth is the major factor, a price mechanism like the so-called "relative value scale" may not be a sufficient remedy.

The best cost-control mechanism for physician services is a competitive system that puts patients, through their own choosing, under the care of physicians who utilize services appropriately.

There is a glut of health care providers now in the U.S., of both doctors and hospitals. It is a buyers' market and the Federal government should take advantage of it.

Our near-term strategy includes price restraint and more intensive utilization review on a case-by-case basis.

We are also developing a payment reform proposal that embodies a broader set of principles involving both cost and quality: a preferred provider organization within the Medicare program.

We would select a sub-set of doctors -- careful and appropriate practitioners of quality medicine -- and then steer a volume of patients to them using economic incentives, such as lower beneficiary copayments.

Private Health Plans

However, having told you about our cost containment problems, let me add clearly: There is a better way of dealing with these problems: the Private Health Plan Option under Medicare.

In our unique political system, with its separation of powers, and its checks and balances, Americans have come to appreciate the benefits of a federation, a decentralized government framework. I believe that it is also better to rely on a decentralized system in conjunction with private health plans in Medicare.

Under a 1982 law change, much has been accomplished with HMOs and CMPs in Medicare.

Medicare risk contracts are available as a choice for more than one-half of our 31 million beneficiaries, and about one million have so chosen. The advantages of these plans to our beneficiaries include -- more benefits, lower copayments, and less paperwork.

I am not here to sell HMOs. They must prove themselves in competition with the traditional Medicare program, which becomes more efficient daily.

We are engaged in a "market test" of the Private Health Plan Option in Medicare.

It is up to us in HHS to prove whether we can operate the program in a fair and beneficial manner.

We also seek to launch a series of demonstrations of another type of capitated plan -- based on pre-formed groups of Medicare beneficiaries.

The retired enrollees in an employer or union operated health plan would be able to participate in a Medicare Insured Group demonstration.

We recently signed an agreement with the Amalgamated Life Insurance Company to develop such a demonstration.

The essential philosophy behind the Private Option is choice...choice for consumers and choice for physicians, who are the ones best able to design local health-care plans to meet local needs.

III. The Future of Health Care

Let me close with some additional reflections on the future.

To begin with, the new "Medicare Catastrophic Coverage Act" has recently been enacted. Without going into all the details here, I will simply make a few remarks.

First, this new revision of Medicare is the most sweeping improvement in the Medicare program since its inception in 1965. Medicare has been beefed up to provide real protection against financial ruin, for those who suffer from acute illnesses or injuries.

Second, Medicare has been simplified enormously for everyone. Many of the program's confusing features have been eliminated, such as "reserve days," and "benefit periods." We are very pleased about the comprehensive services we will be able to offer to Medicare beneficiaries.

Looking to the future of the Medicare program, it is increasingly obvious that we must eliminate the disparity between conventional wisdom and reality in health care.

For example, the conventional view is that major "cuts" have been made in the Medicare program in recent years. In fact, Medicare has grown more rapidly than the Department of Defense budget between 1981 and 1988.

Further, convention argues that the American people value health so highly that they will pay any price to have the finest health care.

However, reality is more complex than slogans.

I believe that we will always devote a large share of our economy to health care.

However, I believe that there is a growing demand for value in health spending: first, value in the sense of paying for procedures that are effective; and second, value in the sense of investing dollars in ways that have the most return.

Surely there are limits to our resources. One of the uncomfortable suspicions dawning in the late 1980s, is that our aspirations may outstrip our resources. Therefore, we must do a better job of targeting health care spending.

This will necessitate hard choices -- by people of good will. As I said, I believe that decentralized decisions will prove to be better than centralized ones.

The sort of choices we will have to make concern issues like putting our resources into maternal and child health care instead of some experimental therapies, perhaps. A crucial point here is for the states to make these decisions themselves, because each state has different needs.

For example, in Alabama we have a very high rate of infant mortality. The state officials there have put together a creative plan in Jefferson County to provide managed pre- and post-natal care for indigent mothers. This is the sort of program you would not get unless we have decentralized health care programs.

Looking carefully at the American health care system, despite our deep-seated ambivalence about intruding on physician independence, I do not believe that we can have both unfettered physician decision-making and cost containment.

There is surely room for debate about how to constrain physician decision-making, but not whether to do so.

As we analyze the system, is the glass half-empty, or half-full?

In a time of change, the health care community should not lose sight of its mission. Medicine must maintain its fiduciary role in caring for patients.

This means doing what we believe is best for our patients, but also being committed to measure our own performance and that of our colleagues...and acting on this information.

In the long run, professional accountability will be the primary way the medical profession will maintain its credibility in the new age of information and accountability.

We must resist telling ourselves that the old ways were the best ways, and commit ourselves to the enterprise ahead.

In this way, today's economic reality can be an instrument for a profound and satisfying change in American health care.

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